DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Dyson

OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 0 7

2. STATE: Wisconsin

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ ~~0~~ 400 K
b. FFY 2001 $ ~~0~~ 1,260 K

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A pp. 6,7,14,14.1,33.6,50,51,52 →
new page 6.3, 6.5, 6.1, 6.2, 6.4,
new pg 7.1, 7.2, 7.3, 7.4, 7.5,

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same ~~p 6, 7,~~

10. SUBJECT OF AMENDMENT:
Inpatient Hospital Reimbursement

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

Melissa A Mullen

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Peggy L. Bartels

13. TYPED NAME:
Peggy L. Bartels

14. TITLE:
Administrator, Division of Health Care Financing

15. DATE SUBMITTED:
September 21, 2000

16. RETURN TO:
Division of Health Care Financing
Peggy L. Bartels, Administrator
P.O. Box 309
Madison, WI 53701-0309

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9/26/00

18. DATE APPROVED: 11/25/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:
Cheryl A Harris

21. TYPED NAME:
Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

5100 STANDARDIZED DRG PAYMENT FACTORS

Certain standard factors are used in the determining the amount of payment hospitals receive for services covered by the DRG based payment method. The Department adjusts these standard factors for each rate year, July 1 through June 30. They include the DRG grouper, the DRG weights and the standard DRG group rates.

5130 DRG Grouper

The DRG grouper is a patient classification software system which results in a patient stay being classified into one "diagnosis related group" (DRG). The WMP DRG reimbursement system uses the grouper developed for Medicare based on "major diagnostic categories" (MDCs). For newborns, WMP has enhanced the grouper's MDC 15, Newborns and Other Neonates with Conditions Originating in the Perinatal Period. For psychiatric stays, the grouper's MDC 19, Mental Diseases and Disorders, is also enhanced.

Annually, beginning with July 1, 1992, updated versions of the Medicare grouper will be used by the WMP. The Medicare grouper version, which is released by HCFA for use by Medicare beginning on October 1 of each calendar year, will be implemented for MA discharges occurring on and after July 1 of the subsequent calendar year. (For example, on October 1, 1991 HCFA began to use Version IX of the Medicare grouper. Therefore, for dates of discharge on and after July 1, 1992, the WMP will apply that Version IX grouper.)

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TN # 99-013 Approval Date _____ Effective Date 7/1/00

5140 DRG Weights

DRG weights reflect the relative resource consumption of each inpatient stay. The weights are determined from an analysis of past services provided by hospitals, the claim charges for those services and the relative cost of those services. WMP recipient inpatient hospital claims are used in order that the weights which are developed are relevant to the types and scope of services provided to WMP recipients.

Annually, beginning with July 1, 1992, revised DRG weights will be established based on (1) the updated version of the Medicare grouper, (2) more current claims information and (3) more current inpatient hospital cost report information.

5140.1 Claims Used. Claims for a period of at least three years for WMP certified hospital providers in Wisconsin are used. The selected period of claims is not to end more than twenty-four months nor less than nine months prior to the July 1st day on which the revised DRG weights are to be implemented. Claims not covered by WMP's DRG based payment system are not used. These are claims for which payment is made at rates determined under Sections 6000 and 7000.

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5140.2 Cost Report Used. The WMP uses the cost report for each hospital's most recently completed reporting period for which an audit adjusted cost report is available to the Department as of the February 28th date prior to the July 1st day on which the revised DRG weights are to be implemented except the Department may, at its option, use audited cost reports it receives later. Costs are inflated as described below for the calculation of weights.

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5140.3 Weights Calculated.

The updated version of the Medicare grouper described in section 5130 above is applied to the historical claims from the period described in subsection 5140.1 above. Each claim is classified to and assigned its appropriate diagnosis related grouping (DRG) by the grouper.

The cost of each inpatient hospital claim is calculated. This is a hospital-specific claim cost that requires correlating the services charged on the claim to related cost centers of the hospital's cost report. For each claim, the days of the stay are multiplied by the accommodation costs per diem from the cost report providing a cost for accommodations. Ancillary service charges are multiplied by cost-to-charge ratios of ancillary cost centers in the respective hospital's cost report providing a cost for ancillary services. The resulting accommodation costs and ancillary service costs of each claim is summed resulting in the total cost of the inpatient stay.

The cost of each inpatient stay is further standardized (or adjusted) for area wage differentials and reduced for the cost attributed to capital costs, medical education costs and outlier costs.

Each claim's cost is inflated by an inflation multiplier to the current rate year. The inflation multiplier is derived from indices in the publication, "Health Care Cost Review", that is published quarterly by the Standard & Poor's DRI division of The McGraw-Hill Companies. Specifically used are the total market basket indices as listed by calendar quarter in the tables for HCFA's hospital prospective reimbursement. In the publication's second quarter 2000 edition, this table is entitled "HCFA Hospital Reimbursement Market Based (PPS) – Historical Data" for historical quarters and, for forecasted future quarters, the table is entitled "HCFA Hospital Prospective Reimbursement Market Basket (PPS) – Quarterly Forecasts".

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The average cost of the claims by each DRG is calculated. A combined average cost of all medical and surgical DRG claims is calculated. The weight for each respective DRG is the average cost of the respective DRG's claims divided by the average cost of all medical and surgical DRG claims. In this way, weights are established for over 600 DRGs.

Random anomalies and incongruities in the resulting weights are reviewed and analyzed in the light of the prior year weights and the cost and volume of claims involved. The questioned DRG weights are adjusted, if considered appropriate, to a reasonable amount based on the analysis. It should be noted that low-volume DRGs are especially vulnerable for significant year-to-year swings in their weight. A significant decrease in the weight of any individual DRG is limited unless cost, volume and central tendency and deviation data justify the significant decrease. A listing of the resulting proposed and final DRG weights are disseminated to in-state and major border status hospitals.

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5140.4 Cochlear Implants.

A separate weighting factor is provided for inpatient hospital stays for cochlear implants. Payment is available upon written request by the hospital for payment at this weight and is only available for a claim that covers cochlear implant surgery and the cost of the apparatus. This is a low volume inpatient procedure for Medicaid recipients but is significantly more expensive than the broadly inclusive DRG #49, major head and neck procedures, in which cochlear implants are grouped (assigned). A claim for surgery without the apparatus cost will be covered under DRG #49. The cochlear implant weight was established based on the cost of 17 inpatient stays from February 1991 to August 1993. This set of claims covered some WMP recipients but mostly persons not covered by WMP. When a sufficient number of inpatient claims from a current period of no more than 7 years is available for WMP recipients receiving cochlear implants, a weight will be calculated based on those claims. The method of calculating a weight is that described above for other weights.

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5150 DRG Weights For Psychiatric Stays

A psychiatric stay is an inpatient stay that is assigned to one of the nine DRGs in the mental diseases and disorders major diagnostic category of the Medicare grouper logic. A stay is identified as a psychiatric stay by applying the Medicare grouper to a claim in order to assign a DRG. This is part of the weight setting process described subsection 5140.3.

The WMP has expanded these nine DRGs for mental diseases and disorders into two additional stratifications. First, each of the nine DRGs are split into two age groupings, over-17 and 17-and-younger. Second, the resulting 18 groupings are further split into four groups by type of hospital, specifically; (a) Milwaukee County Mental Health Complex IMD; (b) all other IMD hospitals; (c) general medical-surgical hospitals with Medicare-exempt psychiatric units; and (d) other general medical-surgical hospitals not having Medicare-exempt psychiatric units. Each hospital is identified as being one and only one of these four types of hospitals.

A claim can be assigned to one of the 72 mutually exclusive groups for psychiatric DRG weights, that is, nine psychiatric DRGs in each of two age groups for four types of hospitals. A claim for a psychiatric stay is assigned to an age strata based on the recipient's age at the time of the inpatient stay. The claim is assigned the hospital-type strata to which the provider hospital belongs.

For establishing the weights, the claims are included in the process described in subsection 5140.3. The cost of each claim is calculated, the average cost of the claims in each of the 72 groupings is calculated and 72 psychiatric weights calculated, one for each group.

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5150 DRG Weights For Psychiatric Stays, Continuation

However, after stratifiying the claims, some of the 72 groupings may include only a small number of claims or no claims. A weight is needed for any potential future claims in a grouping even though no past claims have been assigned to a grouping. Also, a small number of claims in a grouping can result in aberant swings in a grouping's weight from year to year. To minimize such swings, an alternate method is used to establish a weight for those groups with a small number of claims or no claims. First, a weight is calculated for each psychiatric DRG using the cost from all hospitals for the respective DRG without regard to type of hospital. This results in 18 psychiatric weights - nine psychiatric DRGs in each of two age groups. Second, a ratio is calculated for each group of hospitals to identify each group's relative cost of an average psychiatric stay to the average cost of psychiatric stays for all hospitals. This ratio is the average cost of psychiatric claims for each of the four types of hospitals divided by the average cost of all psychiatric claims over all hospitals. Finally, this group ratio times each of the 18 psychiatric weights from the first step results in a smoothed-out DRG weight for any of the 72 psychiatric stay groups that have a small number or no claims.

As noted in subsection 5140.3, random anomalies and incongruities in the resulting weights are reviewed and adjustments made if considered appropriate. However, the alternate method described in the above paragraph helps reduce and may eliminate such questions and adjustments for psychiatric DRG weights.

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5150 DRG Weights For Psychiatric Stays, Continuation

If a hospital's psychiatric unit is not Medicare exempt, it may be considered an exempt unit for the purposes of this Plan as is explained in section 11900, item H, "Adjustment for Hospitals With Psychiatric Units Which Are Not Medicare-Exempt".

All hospitals placed in group c. above for psychiatric stays, whether actually Medicare-exempt or deemed Medicare-exempt by the WMAP, are expected to treat patients with psychiatric DRGs in the exempt units. If the Department finds through audit, self-reporting or any other means that a claim was assigned to a psychiatric DRG but the patient was not treated in the exempt unit, the Department will recoup the difference in payment between what was paid under psychiatric group c. vs. what would have been paid under psychiatric group d.

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5160 Standard DRG Group Rates

Standard DRG group rates were based on the level of expenditures made to hospitals for WMP inpatient stays in calendar year 1989. Subtracted from these expenditures were (a) payments to hospitals for services not included in the DRG payment system such as, but not limited to, ventilator-assisted patients and AIDS patients' services; (b) capital payments; (c) direct medical education payments; (d) indirect medical education payments; (e) disproportionate share adjustment payment; and (f) outlier payments. The amount was further reduced by the extra expenditures attributable to HMO adverse selection that was 10% of the expenditure for cases in Milwaukee County. The resulting net expenditure amount divided by hospital stays from 1989 generated a statewide average base expenditure. (The number of hospital stays used excluded the stays covered by non-DRG payments described in item (a) above.)

The net IMD hospital expenditures per case were found to differ significantly from statewide average expenditures. This difference was recognized by establishing separate rates for IMD hospitals and general medical and surgical hospitals.

The statewide average base expenditure is adjusted annually according to funding amounts authorized through the State's biennial budget process.

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5160 Standard DRG Group Rates, Continued

Enrollment in the HMO Preferred Enrollment Initiative (PEI) has been mandatory for over ten years for Milwaukee County Medicaid recipients in certain medical status categories such as those for children and mothers. WMP recipients not mandated for HMO coverage are in general, but not limited to, aged and disabled. Because the non-HMO, fee-for-service Medicaid population in Milwaukee requires more intensive medical care and is more costly to care for than the fee-for-service Medicaid population in other counties, the standard DRG group rates will be 10% greater for Milwaukee County hospitals than for hospitals in other counties to allow for any HMO adverse selection occurring in Milwaukee. If the HMO/PEI ceases to be mandatory in Milwaukee County, the WMAP will eliminate the Milwaukee county-wide adverse selection adjustment from hospital-specific DRG base rates. A specific hospital may request an administrative adjustment under section 11900, item I, "Adjustment for PEI Ceasing to be Mandatory."

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Based on the analysis described in the above discussion, separate base rates are provided for the following four groups of hospitals. Four group rates allow for (1) the difference described above for general medical and surgical hospitals and the IMD hospitals and (2) the difference caused by HMO adverse selection described above. The result is a standard DRG rate for each of the following four groups.

-- General Medical and Surgical Hospitals in Milwaukee County
-- General Medical and Surgical Hospitals not in Milwaukee County
-- Hospital IMDs in Milwaukee County
-- Hospital IMDs not in Milwaukee County

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5260 Rural Hospital Adjustment Percentage

5261 Qualifying Criteria.

A hospital may qualify for a rural hospital adjustment if it meets the following conditions. Administrative adjustments regarding qualifying for the rural hospital adjustment and the adjustment percentage are described in section 11900, items K, L and M. Critical access hospitals under section 5900 are not eligible to receive an adjustment under this section.

1. The hospital is located in Wisconsin, is not located in a HCFA defined metropolitan statistical area (MSA), and has the WMP's Wisconsin rural area wage index used in calculation of its hospital-specific DRG base rate.
2. As of January 1, 1991, the hospital was classified in a rural wage area by Medicare.
3. The hospital is not classified as a Rural Referral Center by Medicare.
4. The hospital did not exceed the median amount for urban hospitals in Wisconsin for each of the following operating statistics for the statistical years described below: (a) total discharges excluding newborns, (b) the Medicare case-mix index, and (c) the Wisconsin Medicaid case-mix index.
5. For rate years beginning on and after July 1, 1998, the combined Medicare and Medicaid utilization rate of the hospital is determined to be equal to or greater than 50.0%. For rate years beginning prior to July 1, 1998, the combined Medicare and Medicaid utilization rate has been equal to or greater than 55.0%.

For criteria item 1 above. The reclassification to an urban wage area, of a hospital which is located in a rural wage area, shall be rescinded by the Department if the urban wage area index to be applied to the hospital is lesser than the rural hospital adjustment. This allows the hospital to receive the urban wage adjustment or the rural hospital adjustment, whichever is greater. (Reference section 5226.)

For criteria item 4 above. The statistical year for total discharges excluding newborns will be the fiscal year of the hospital. The statistical year for the Wisconsin Medicaid case-mix index will be the state fiscal year. The statistical year for the Medicare case-mix index will be the federal fiscal year. The fiscal year to be used is that fiscal year which ended in the second calendar year preceding the annual July 1 rate update. (For example, for July 1, 1996 rate updates, the statistical years will be fiscal years that ended in 1994.) Urban hospital means any hospital located in Wisconsin which is located in a HCFA defined metropolitan statistical area (MSA) or which has a WMAP urban area wage index used in calculation of its hospital-specific DRG base rate.

For criteria item 5 above. The combined Medicare and Medicaid utilization rate is determined by dividing the total Medicare and Medicaid inpatient days by the total inpatient days. Long-term care days from hospital swing-beds shall not be included as inpatient days in this calculation. The inpatient days will be from the individual hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update. However, the Department may at its option use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th prior to the annual rate update precedes the beginning date of the rate year by more than three years, three months. If the audited cost report which is used is more than three years old, the hospital may request an administrative adjustment under §11900, item B, to have its rural adjustment based on a more current audited cost report. For the base cost reports to be used for hospitals combining operations, see section 5860.

5262 Adjustment Percentage.

The amount of the rural hospital adjustment will be based on a qualifying hospital's Medicaid utilization rate. The Medicaid utilization rate is determined by dividing the total Medicaid inpatient days by the total inpatient days from the individual hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update. However, the Department may at its option use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th prior to the annual rate update precedes the beginning date of the rate year by more than three years, three months. Long-term care days from hospital swing-beds shall not be included as inpatient days in the denominator of this calculation. The resulting Medicaid utilization rate shall be used to determine the adjustment percentage for the hospital-specific DRG base rate according to the following table.

Medicaid Utilization Rate	Rural Hospital Adjustment Percentage Effective On and After July 1,2000
Up through 4.99%	8.00%
5.0% through 9.99%	17.00%
10.0% through 14.99%	26.00%
15.0% and greater	35.00%

5270 Institutions for Mental Disease (IMD) Hospital Length of Stay Adjustment

A length of stay (LOS) adjustment is provided to the hospital specific DRG base rate of qualifying IMD hospitals. This adjustment applies for the rate year beginning July 1, 1999 and ending June 30, 2000. To qualify, an IMD hospital's average length of stay for psychiatric DRG stays must exceed the average length of stay of all psychiatric DRG stays in the hospitals' peer group described in section 5150. The amount of the adjustment is determined according to the calculation and amounts described in this section.

((Hospital's LOS / Peer Group LOS) – 1.00) * .90 = IMD Length of Stay adjustment ratio

An IMD hospital qualifies for this adjustment only if the resulting adjustment ratio is a positive amount.

Hospital's LOS is the amount that is calculated by dividing the hospital's number of days of qualifying stays by the number of qualifying stays. Qualifying stays meet the following criteria.

(1) The stay was covered in full or in part by the WMAP's DRG based payment system.
(2) The stay was assigned (or grouped) to a DRG in MDC 19, the medical diagnostic category (MDC) for mental diseases and disorders.
(3) The stay is 60 days or shorter in length. Stays exceeding 60 days are excluded.
(4) The WMAP recipient was discharged from the hospital in the rate year beginning two years prior to the current rate year. For example, for the adjustment for the rate year beginning July 1, 1999, discharges in the rate year July 1, 1997 to June 30, 1998 are used. The number of days of these qualifying stays are used in the calculation without regard as to when the recipient was admitted to the hospital.

Peer Group LOS is the amount that is calculated by dividing the number of days of the qualifying stays by the number of the qualifying stays for the respective hospital's peer group described in section 5150. Qualifying stays meet the following criteria.

(1) The stay was covered in full or in part by the WMAP's DRG based payment system.
(2) The stay was assigned (or grouped) to a DRG in MDC 19, the medical diagnostic category (MDC) for mental diseases and disorders.
(3) The WMAP recipient was discharged from the hospital in that period from which claims were used to establish DRG weights for the current rate year. This period of claims used is described in section 5140. For example, for the adjustment for the rate year beginning July 1, 1999, the claims used for establishing DRG weighting factors are from the three year period July 1, 1995 to June 30, 1998. The number of days of these qualifying stays are used in the calculation without regard as to when the recipient was admitted to the hospital.

Each item (1) above excludes recipient stays that are: (a) covered by a managed care organization (MCO or HMO) under contract with the WMAP; (b) paid in full or part by Medicare (Title 18); or (c) stays for which the WMAP made no payment due to the stay being covered by some other payor such as private hospitalization insurance.

8270 Indigent Care Allowance Target Funding.

For the rate year July 1, 2000 through June 30, 2001 , the total target funding for the inpatient indigent care allowance is $8,844,398 .

For the rate year July 1, 2001 through June 30, 2002 , and each rate year thereafter, the total target funding for the inpatient indigent care allowance is $ 8,844,398.

8272 GA Disproportionate Share Supplement (GADSH) Target Funding

For the rate year July 1, 2000 through June 30, 2001, the target funding for the general assistance disproportionate share supplement is $5,280,000 .

For the rate year July 1, 2001 through June 30, 2002 , and each year thereafter, the target funding for the general assistance disproportionate share supplement is $5,280,000.

The total amount to be paid to qualifying hospitals for GA disproportionate share supplements is not to exceed the amount of the disproportionate share funding ceiling for each federal fiscal year ending September 30th that is assigned to the WMP under 42 CFR 447.296 through 447.299, reduced for disproportionate share hospital payments under §5240.

Based on current estimates of the federal funding ceiling available for this supplement, the following amounts will be used. These amounts will be reduced if ceiling amounts provided by the federal Health Care Financing Administration under 42 CFR 447.296 through 447.299 do not provide sufficient funding for disproportionate share payments of §5240 and this section.

The funding targets for the rate year July 1, 2000 through June 30, 2001 are:

First Period	$ 1,320,000	For the fourth quarter of federal fiscal year ending September 30, 2000 , that is, the three months July 1, 2000 through September 30, 2000 .
Second Period	$3,960,000	Combined amount for the first three-quarters of federal fiscal year ending September 30, 2001, that is, the nine months October 1, 2000 through June 30, 2001.
Annual Total	$5,280,000	

The funding targets for the rate year July 1, 2001 through June 30, 2002 , and each rate year thereafter are:

First Period	$1,320,000	For the fourth quarter of federal fiscal year ending September 30 during the rate year, that is, the three months July through September.
Second Period	$3,960,000	Combined amount for the first three quarters of the federal fiscal year that ends the September 30th after the end of the rate year, that is, the nine months October through June.
Annual Total	$5,280,000	

APPENDIX SECTION 27000
AREA WAGE INDICES
Effective July 1, 2000

Following wage area indices are based on wage data from the HCFA 1997-98 hospital wage survey as of May 15, 1999.

WAGE AREAS FOR WISCONSIN HOSPITALS	For Original Remaining Hospitals in Area	For Hospitals Reclassified to Area
Appleton/Neenah/Oshkosh	0.9465	None
Eau Claire	0.9586	None
Green Bay	0.9763	None
Janesville/Beloit	1.0283	None
Kenosha	0.9288	None
La Crosse	0.9556	None
Madison	1.0624	1.0624
Milwaukee County	1.049	None
Ozaukee-Washington-Waukesha Counties	1.0382	1.0382
Racine	0.9854	None
Sheboygan	0.9157	None
Superior, WI / Duluth, MN	1.1136	None
Wausau	1.0114	1.0114
Rural Wisconsin	0.9157	None

WAGE AREAS FOR BORDER STATUS HOSPITALS	For Original Remaining Hospitals in Area	For Hospitals Reclassified to Area
Twin Cities, Minnesota (St. Paul, Minneapolis, Coon Rapids, Edina, Lake City, Robinsdale, Stillwater, Chisago City, Hasting)	1.1247	None
Duluth, Minnesota	1.0933	None
Rochester, Minnesota	1.1656	None
Rockford, Illinois	0.9435	None
Dubuque, Iowa	0.9112	None
Chicago - Woodstock, Harvard, Illinois	1.0687	None
Iowa City, Iowa	1.0318	None
Rural Illinois	0.9086	None
Rural Minnesota	0.9798	None
Rural Michigan	0.904	None

APPENDIX SECTION 27100

DISPROPORTIONATE SHARE ADJUSTMENT AMOUNTS UNDER MEDICAID UTILIZATION METHOD OF SECTION 5243

Effective July 1, 2000 , a hospital's disproportionate share adjustment factor under section 4243 is calculated according to the following formula where:

18.07%	=	Medicaid inpatient utilization rate at one standard deviation above the statewide mean Medicaid utilization rate.
M	=	The hospital's Medicaid inpatient utilization rate for hospitals with a utilization rate greater than 18.07%.
.0765	=	Linear slope factor allowing proportional increase in disproportionate share adjustment as utilization rate (M) increases.

Formula:

[(M - 18.07%) x .0765] + 3% = Hospital's Specific Disproportionate Share Adjustment Percentage

APPENDIX 27200
INFLATION RATE MULTIPLIERS
FOR ADMINISTRATIVE ADJUSTMENTS
FOR RATES EFFECTIVE JULY 1, 2000 THROUGH JUNE 30, 2001

Inflation rates to be applied in calculating the following administrative adjustments of §11900:
Item B -- Capital and direct medical education payment based on cost report more than three years old
Item C -- Capital payment adjustment for major capitalized expenditures
Item D -- Adjustment for changes in medical education

Month Fiscal Year Ended	Inflation Multiplier
1994	
Jan-94	1.2092
Feb-94	1.2092
Mar-94	1.2092
Apr-94	1.2023
May-94	1.2023
Jun-94	1.2023
Jul-94	1.1921
Aug-94	1.1921
Sep-94	1.1921
Oct-94	1.1832
Nov-94	1.1832
Dec-94	1.1832
1995	
Jan-95	1.1722
Feb-95	1.1722
Mar-95	1.1722
Apr-95	1.1625
May-95	1.1625
Jun-95	1.1625
Jul-95	1.1551
Aug-95	1.1551
Sep-95	1.1551
Oct-95	1.1520
Nov-95	1.1520
Dec-95	1.1520
1996	
Jan-96	1.1426
Feb-96	1.1426
Mar-96	1.1426
Apr-96	1.1385
May-96	1.1385
Jun-96	1.1385
Jul-96	1.1314
Aug-96	1.1314
Sep-96	1.1314
Oct-96	1.1273
Nov-96	1.1273
Dec-96	1.1273

Month Fiscal Year Ended	Inflation Multiplier
1997	
Jan-97	1.1223
Feb-97	1.1223
Mar-97	1.1223
Apr-97	1.1174
May-97	1.1174
Jun-97	1.1174
Jul-97	1.1086
Aug-97	1.1086
Sep-97	1.1086
Oct-97	1.1009
Nov-97	1.1009
Dec-97	1.1009
1998	
Jan-98	1.0933
Feb-98	1.0933
Mar-98	1.0933
Apr-98	1.0821
May-98	1.0821
Jun-98	1.0821
Jul-98	1.0738
Aug-98	1.0738
Sep-98	1.0738
Oct-98	1.0702
Nov-98	1.0702
Dec-98	1.0702
1999	
Jan-99	1.0657
Feb-99	1.0657
Mar-99	1.0657
Apr-99	1.0585
May-99	1.0585
Jun-99	1.0585
Jul-99	1.0498
Aug-99	1.0498
Sep-99	1.0498
Oct-99	1.0428
Nov-99	1.0428
Dec-99	1.0428

Month Fiscal Year Ended	Inflation Multiplier
2000	
Jan-00	1.0343
Feb-00	1.0343
Mar-00	1.0343
Apr-00	1.0284
May-00	1.0284
Jun-00	1.0284
Jul-00	1.0210
Aug-00	1.0210
Sep-00	1.0210
Oct-00	1.0144
Nov-00	1.0144
Dec-00	1.0144
2001	
Jan-2001	1.0072
Feb-2001	1.0072
Mar-2001	1.0072
Apr-2001	1.0000
May-2001	1.0000
Jun-2001	1.0000
Jul-2001	0.9929
Aug-2001	0.9929
Sep-2001	0.9929
Oct-2001	0.9867
Nov-2001	0.9867
Dec-2001	0.9867
2002	
Jan-2002	0.9799
Feb-2002	0.9799
Mar-2002	0.9799

(Pages 53 and 54 not used. Next page is 55)